



## CLINICAL SKILLS CHECKLIST *Pharmacist*

Please list any limitations or comments you may have on a separate sheet

<b>IDENTIFYING INFORMATION</b>	Last Name	First name	Middle name	Previous Surname					
<b>CERTIFICATIONS</b>	<input type="checkbox"/> BLS expiration date: _____ <input type="checkbox"/> ACLS expiration date: _____ <input type="checkbox"/> Other: expiration date: _____								
<b>LICENSES/ CERTIFICATIONS</b> <small>List all states in which you are or have ever been licensed and/or certified, beginning with your original state license</small>	Original State License/Certificate	License/Certificate #	Expiration Date	State License/Certificate	License/Certificate #	Expiration Date			
	State License/Certificate	License/Certificate #	Expiration Date	State License/Certificate	License/Certificate #	Expiration Date			
	Please list other certifications, licenses, permits, registrations, etc. (including inactive)								
<b>DISPENSE CONTROLLED SUBSTANCE PERMIT</b>	Permit Number			Expiration Date					
	Permit Number			Expiration Date					
<b>AREAS OF INTEREST</b>	<input type="checkbox"/> Hospital-based <input type="checkbox"/> Retail <input type="checkbox"/> Treatment oriented practice <input type="checkbox"/> Other healthcare facilities: _____								
<b>CLINICAL EXPERIENCE</b>	<i>Please rate your skills in the areas below using the following values:          1 = No experience    2 = Some experience (less than 1 yr.)    3 = Experienced (At least 1 yr.)    4 = Highly experienced (2 yrs. or more)</i>								
	<b>Medication Classifications</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	<b>Computer-based</b> <i>continued</i>			
Analgesics – Non-narcotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	DEA website access	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Narcotic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Electronic medication systems :				
Antibiotics/Anti-Infectives – Topical	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	ADSX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Systemic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CareManagement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antineoplastics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cerner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	CPSI	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antiarrhythmics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anticoagulants	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HBOC	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihypertensives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Meditech	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antilipidemics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nexgen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Endocrine/Metabolic Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	PDX	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	RX3000	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pulmonary/Respiratory Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
CNS Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Medication dispensing systems:				
Psychotherapeutic Agents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Abbott	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Accudose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Medication Preparation</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Baxter	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
IV Admixture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	McKesson	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Compounding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pyxis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TPN preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
					Third-party billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<b>Computer-based</b>	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b>	Patient education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Calculations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Veterinary prescriptions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug interactions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Average number of prescriptions filled per day? _____									
Additional Clinical Skills: _____									
Comments (if indicated): _____									

I affirm that all information given on this page is true and accurate.

Initials \_\_\_\_\_ Date \_\_\_\_\_